DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0499

December 6, 2000

CHDP Provider Information Notice No: 00-11

TO: CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PROVIDERS

SUBJECT: CHANGES IN CHDP PROVIDER LETTERS AND MESSAGES

This Information Notice is to advise you of changes in CHDP letters and messages. These changes were effective October 2, 2000.

In recent years, the CHDP claims processing system has undergone several modifications to simplify claims processing. One of the changes to the system was to ensure the promotion of clearer communication with the provider community through generation of more detailed and professional CHDP letters and messages. In order to accomplish this, the CHDP program has developed new and reformatted provider letters.

Enclosed are samples of these letters and, when applicable, their related messages/explanations. The following is provided to clarify the intent of the changes for three specific letters:

A. Provider Correction Request (PCR):

This letter was redesigned to mirror, as closely as possible, the components of the PM 160 claim form. The changes will assist providers in understanding the problem(s) identified on the claim as it was processed. The portion of the letter requesting additional information or changes has been divided into three sections: 1) tests, 2) immunizations, and 3) other corrections. It is important to understand that only those sections of the claim with problems will be addressed in the letter related to the claim. For example, if there is only a problem with a test code, the sections for "immunizations" and "other corrections" will not appear on the letter you receive. Also included in each section are the PCR message code number(s) and the related message(s).

B. Notice of Claim Denial from Critical Edit

This letter has been reformatted to include a denial code number and the related message for each identified error. For those claims that are denied because a PCR was not returned or was incorrectly completed (denial codes 51 and 52), the errors that were originally identified on the PCR will display. All other denial letters will identify the reason(s) for denial and, when applicable, other errors identified on the claim.

C. Notice of Claim Denial from Fee Adjustment Edit

This letter was created to identify claim denials originating from fee adjustments. In the past this type of denial would appear on the "Notice of Claim Denial" letter. This new letter also displays fee adjustment code(s) and related message(s).

The remaining letters have been changed to provide you with as much detail as possible. The enclosure identifying all of the letters and messages replaces Appendices B and C and pages 500.12-500.15 (Adjustment Codes) of your CHDP Provider Manual.

Thank you for your continued support of the CHDP program. If you have any questions regarding this notice, please contact your local CHDP program office.

Maridee Gregory MD

Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosure

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF PROVIDER CORRECTION REQUEST

05-01-2000

GENERAL SPECIALTIES, INC
897 CORRECTIONAL DRIVE
SUITE B, 2ND FLOOR
CITY OF INDUSTRY, CA 98972-98

Provider Number: PCRPROV123

Dear CHDP provider:

The information on the Confidential Screening Billing Report (PM 160) referenced below is missing or incorrect. In order to process the claim for payment, it is necessary for you to provide additional information. Please enter the requested information in the spaces provided on the following pages. This notice must be signed by you or your representative and returned to the address indicated below by 07-01-2000.

EDS/CHDP
Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

If you need assistance completing this request, refer to the CHDP Provider Manual or contact your local CHDP program. Thank you for your participation in the CHDP Program.

PM 160 Information:

Medi-Cal Recipient ID:	987654321
Patient Name:	O'CONNELLY, PATRICK
Medical Record Number:	MEDREC9876
Date of Birth:	11-11-1983
Claim Control Number:	0000987654321
Date of Service:	04-20-2000
Total Fees:	$ 99.88

Summary of Missing or Incorrect Information

The following page(s) detail the missing or incorrect information. Each page must be signed and dated, with comments added as desired.

PM160 Information for Patient:	**O'CONNELLY, PATRICK**	**Claim Control Number:**	**0000987654321**
Medi-Cal Recipient ID:	**987654321**	**Provider Number:**	**PCRPROV123**
Medical Record Number:	**MEDREC9876**	**Date of Service:**	**04-20-2000**
Date of Birth:	**11-11-1983**	**Processing Date:**	**05-01-2000**

Supply the missing information as indicated by the spaces provided below for each listed procedure. For more information, use the PCR message codes referenced in your CHDP Provider Manual. Existing claim information is listed in parentheses.

Provide checkmark in Column A or B, or follow-up codes in Column C and/or D, and fees if missing or incorrect.

STATE USE ONLY	PCR Msg Code	Description	OTHER TEST CODE	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED NEW C	PROBLEM SUSPECTED KNOWN D	FEES (IF MISSING OR INCORRECT)
03	5	HISTORY AND PHYSICAL ASSESSMENT						
04	5	HISTORY AND PHYSICAL FEE ($12.33)						
06	14	URINALYSIS						
07	14	URINALYSIS FEE ($ 4.32)						$

Provide checkmark in Column A, B, C or D, and fees if missing or incorrect.

STATE USE ONLY	PCR Msg Code	Description	OTHER SHOT CODE	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D	FEES (IF MISSING OR INCORRECT
53	20	OTHER SHOT 1						
55	20	OTHER SHOT 2						
56	20	OTHER SHOT 2 FEE ($12.87)						$

COMMENTS:

SIGNATURE OF PROVIDER OR REPRESENTATIVE **DATE**

PM160 Information for Patient:	**O'CONNELLY, PATRICK**	**Claim Control Number:**	**0000987654321**
Medi-Cal Recipient ID:	**987654321**	**Provider Number:**	**PCRPROV123**
Medical Record Number:	**MEDREC9876**	**Date of Service:**	**04-20-2000**
Date of Birth:	**11-11-1983**	**Processing Date:**	**05-01-2000**

Supply the missing information as indicated by the spaces provided below for each listed procedure. For more information, use the PCR message codes referenced in your CHDP Provider Manual. Existing claim information is listed in parentheses.

STATE USE ONLY	PCR Msg	Description
87	2	**VERIFY BIRTHDATE: (04-29-98) (MM-DD-YY)**
86	3	**VERIFY SEX OF PATIENT: (SEX: X) MALE FEMALE**
76	21	**ALL TOBACCO QUESTIONS MUST BE ANSWERED EITHER "YES" OR "NO":** **1. PATIENT IS EXPOSED TO PASSIVE (SECOND HAND) TOBACCO SMOKE. YES ___ NO ___** **2. TOBACCO USED BY PATIENT. YES ___ NO ___** **3. COUNSELED ABOUT/REFERRED FOR TOBACCO USE PREVENTION/CESSATION. YES ___ NO ___**

COMMENTS:

SIGNATURE OF PROVIDER OR REPRESENTATIVE **DATE**

PROVIDER CORRECTION REQUEST (PCR) MESSAGES AND EXPLANATIONS

1	MESSAGE:	VERIFY PATIENT NAME WITH MEDI-CAL IDENTIFICATION NUMBER
	EXPLANATION:	The patient's name on the claim does not match exactly with the name on the Medi-Cal file. Please correct the name or the Medi-Cal identification number so they will match the Medi-Cal file. If the name on the Medi-Cal file is incorrect, please have family contact their eligibility worker.
2.	MESSAGE:	VERIFY BIRTHDATE
	EXPLANATION:	Verify patient's date of birth. Please provide correct information. If the birthdate of the patient on the Medi-Cal file is incorrect, please have family contact their eligibility worker.
3.	MESSAGE:	VERIFY SEX OF PATIENT
	EXPLANATION:	The box indicating the sex of the patient has either not been marked or the sex indicated on the claim does not match Medi-Cal information. Please provide the correct information. If the sex of the patient on the Medi-Cal file is incorrect, please have family contact their eligibility worker.
4.	MESSAGE:	VERIFY DATE OF SERVICE
	EXPLANATION:	Verify the date of service. Please provide correct information.
5.	MESSAGE:	HISTORY AND PHYSICAL EXAM ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The history and physical exam assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in Column C and/or D. Provide fees if incorrect or not previously entered. If assessment outcome is indicated as Column B, provide a prior PM 160 date in the Comments section of the PCR form.
6.	MESSAGE:	HISTORY AND PHYSICAL EXAM NOT PAYABLE IF COLUMN B IS MARKED
	EXPLANATION:	The assessment outcome for the history and physical exam was marked as refused, contraindicated or not needed (RCN). Fees are not payable with this assessment outcome. If assessment outcome in Column B is correct, adjust fee to zero and provide a prior PM 160 date in the Comments section of the PCR form.
7	MESSAGE:	DENTAL ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The dental assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D.

8.	MESSAGE:	NUTRITIONAL ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The nutritional assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B or follow-up code(s) in C and/or D.
9.	MESSAGE:	ANTICIPATORY GUIDANCE/HEALTH EDUCATION ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The assessment outcome for anticipatory guidance/health education is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code in Column C or D.
10.	MESSAGE:	DEVELOPMENTAL ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The developmental assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D.
11	MESSAGE:	VISION ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The vision assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D and fees if incorrect or previously not entered.
12.	MESSAGE:	AUDIOMETRIC ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The audiometric assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D and fees if incorrect or previously not entered.
13.	MESSAGE:	HEMOGLOBIN/HEMATOCRIT ASSESSMENT OUTCOME REQUIRED
	EXPLANATION	The assessment outcome for hemoglobin or hematocrit is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D. Provide fees if incorrect or previously not entered.
14.	MESSAGE:	URINE DIPSTICK/URINALYSIS ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The urine dipstick or complete urinalysis outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D. Provide fees if incorrect or previously not entered.
15.	MESSAGE:	TB MANTOUX ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	TB Mantoux assessment outcome is missing or incorrectly marked on the claim. Please provide checkmark in Column A or B, or follow-up code(s) in C and/or D. Provide fees if incorrect or not previously entered.

16. MESSAGE: 1st "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED
2nd "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED
3rd "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED

EXPLANATION: The other test code and/or assessment outcome for the indicated other test is missing or incorrectly marked on the claim. Please provide other test code and/or checkmark in Column A or B, or follow-up code(s) in C and/or D. Provide fees if incorrect or previously not entered.

17. MESSAGE: HEIGHT/LENGTH MEASUREMENT REQUIRED
EXPLANATION Height/length in inches and number of quarter (1/4) inches is missing or incorrectly entered. Please enter whole inches in the second and third spaces and convert all fractions of an inch to fourths (1/4) of an inch.

18. MESSAGE: WEIGHT MEASUREMENT REQUIRED
EXPLANATION: Weight in pounds and to the nearest ounce is missing or incorrectly entered. Please enter the values for weight as measured.

19. MESSAGE: BLOOD PRESSURE MEASUREMENT REQUIRED
EXPLANATION: Systolic/Diastolic blood pressure values are required for all children three (3) years of age or older. Please record Systolic/Diastolic values.

20. MESSAGE: IMMUNIZATIONS--SHOT CODE AND/OR ASSESSMENT MISSING OR INCORRECT ON LINE(S) 1-7 (1-3 CURRENTLY)

EXPLANATION: The shot code and/or assessment for the indicated other shot is missing or incorrectly marked on the claim. Please provide shot code and/or checkmark in Column A, B, C, or D. Provide fees if incorrect or previously not entered.

21 MESSAGE: ALL TOBACCO QUESTIONS MUST BE ANSWERED EITHER YES" OR "NO"

EXPLANATION: Answers to tobacco questions are not documented on the claim. Please answer yes or no to each question.

22. MESSAGE: NO PATIENT VISIT CODE
EXPLANATION: The patient visit (new/extended or routine) is missing or incorrectly marked on the claim. Please provide checkmark in Box 1 or 2.

23. MESSAGE: PRIOR PM 160 DATE REQUIRED
EXPLANATION: The partial screen box was marked. Please provide date of last CHDP assessment.

24. MESSAGE: SCREENING PROCEDURE RECHECK DATE (BOX 2) CANNOT BE SAME AS DATE OF SERVICE

EXPLANATION: The recheck date in the "Accompanies Prior PM 160 Dated" (Box 2) is the same as the date of service for the health assessment. Please provide the prior date of service that required a recheck.

If a laboratory provider, please refer to the CHDP Laboratory PM 160 Instructions Manual, Page 10.

25. MESSAGE: VALID MEDI-CAL IDENTIFICATION NUMBER REQUIRED

EXPLANATION: One of the following errors has occurred. Please determine which is applicable and make the appropriate correction:

a) The Medi-Cal identification number provided in the patient eligibility section on the claim is not valid. For instructions on entering a valid number, please refer to the CHDP PM 160 Instructions Manual, Page 115.1 and 115.2 or the CHDP Laboratory PM 160 Instructions Manual, Page 11, **OR**

b) The Medi-Cal number provided is not for the patient. A newborn may only use the mother's Medi-Cal Cal identification number for the month of birth and the month after. The date of service is not during the month of birth or the month after birth. Please provide the patient's own Medi-Cal identification number.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF CLAIM DENIAL FROM CRITICAL EDIT

08-23-2000

JONES, ALBERTA V. MD
1020 VENTURA AVENUE
MEADOWBROOK, CA 93610

Provider Number: SSG745361

Dear CHDP Provider:

Your Confidential Screening Billing Report (PM 160) with the following information has been denied payment for the reasons listed below:

PM 160 Information:

Medi-Cal Recipient ID:	123456789
Patient Name:	OLSEN, RYAN
Medical Record Number:	2210335200
Date of Birth:	08-01-1999
Claim Control Number:	0319294806872
Date of Service:	08-02-2000
Total Fees Billed	$ 50.96

Reason(s) for Denial (See the CHDP Provider Manual for explanation)

Denial Code	Denial Message
44	CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) STATED PATIENT ENROLLED IN A PREPAID HEALTH PLAN
49	ANSWERS TO THE ELIGIBILITY QUESTIONS #1-#3 ON THE CHDP ELIGIBLITY INFORMATION FORM (DHS 4073) WERE NOT ANSWERED "YES" OR "NO"

OTHER ERRORS IDENTIFIED ON THE CLAIM:

20	TB MANTOUX ASSESSMENT OUTCOME REQUIRED

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. If you have any questions regarding this procedure, please contact your local CHDP program.

DENIAL MESSAGES AND EXPLANATIONS RELATED TO CRITICAL EDITS

1	MESSAGE:	VALID PATIENT NAME REQUIRED
	EXPLANATION:	The patient's name on the Medi-Cal eligibility file did not match that used in the Patient's name field on the claim form
2.	MESSAGE:	DATE OF BIRTH LATER THAN SERVICE DATE
	EXPLANATION:	The date of birth on the claim was after the date of service.
3.	MESSAGE:	NUMERIC BIRTHDATE REQUIRED
	EXPLANATION:	A non-numeric birth date was entered.
4.	MESSAGE:	SEX OF PATIENT DIFFERENT THAN MEDI-CAL INFORMATION
	EXPLANATION:	Sex of patient on the PM 160 did not match the information on the Medi-Cal file.
5.	MESSAGE:	PATIENT'S DATE OF BIRTH DIFFERENT THAN MEDI-CAL INFORMATION
	EXPLANATION:	The patient's date of birth on the PM 160 did not match Medi-Cal information.
6.	MESSAGE:	DATE OF SERVICE LATER THAN CURRENT DATE
	EXPLANATION:	The date of service on the claim was after the date the claim was received by the claims processing system.
7.	MESSAGE:	NUMERIC DATE OF SERVICE REQUIRED
	EXPLANATION:	A non-numeric date of service was entered.
8.	MESSAGE:	DAY OF MONTH NOT VALID
	EXPLANATION:	The day of the month was not valid for either the date of service, the date of birth, or the prior PM 160 date. An example would be the 32nd day of a month.
9.	MESSAGE:	MONTH INDICATED NOT VALID
	EXPLANATION:	The month entered in either the date of service, date of birth, or the prior PM 160 date was not a valid month. For example 13 has been entered for a month.
10.	MESSAGE:	DATE OF SERVICE PRIOR TO KNOWN MEDI-CAL ELIGIBILITY
	EXPLANATION:	PM 160 received was for a date of service prior to the eligibility history retained by the Medi-Cal System.
11	MESSAGE:	HISTORY AND PHYSICAL EXAM ASSESSMENT OUTCOME REQUIRED
	EXPLANATION:	The history and physical exam assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A, or follow-up code(s) in Column C and/or D were required.

12. MESSAGE: DENTAL ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The dental assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required.

13. MESSAGE: NUTRITION ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The nutrition assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required

14. MESSAGE: ANTICIPATORY GUIDANCE/HEALTH EDUCATION ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The assessment outcome for anticipatory guidance/health education was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required.

15. MESSAGE: DEVELOPMENTAL ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The developmental assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required.

16. MESSAGE: VISION ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The vision assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required.

17. MESSAGE: AUDIOMETRIC ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The audiometric assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D were required.

18. MESSAGE: HEMOGLOBIN/HEMATOCRIT ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The assessment outcome for hemoglobin or hematocrit was missing or incorrectly marked on the claim. A checkmark was required in Column A or B, or a follow-up code in Column C or D.

19. MESSAGE: URINE DIPSTICK/URINALYSIS ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The urine dipstick or complete urinalysis outcome was missing or incorrectly marked on the claim. Checkmarks in Column A or B, or follow-up code(s) in Column C and/or D were required.

20. MESSAGE: TB MANTOUX ASSESSMENT OUTCOME REQUIRED
EXPLANATION: The TB Mantoux assessment outcome was missing or incorrectly marked on the claim. A checkmark in Column A or B, or follow-up code(s) in Column C and/or D was required.

21	MESSAGE	1st "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED 2nd "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED 3rd "OTHER TEST" CODE 13-22 and/or ASSESSMENT OUTCOME REQUIRED, OTHER TEST TYPE NOT ENTERED or MISSING
	EXPLANATION:	One or more of the "other test" code(s) and/or assessment outcome(s) for the indicated other test(s) was missing or incorrectly marked on the claim. The "Other Test" code and/or checkmark in Column A or B, or follow-up code in Column C or D was required.
22.	MESSAGE	CLARIFICATION NEEDED TO DETERMINE IF "OTHER TEST" CODE 13-22 GIVEN
	EXPLANATION:	Fees entered did not correspond with ASSESSMENT OUTCOME. One or more of the "OTHER TEST" CODE 13-22 tests were billed, however, the claim indicated that the test(s) were not given.
23	MESSAGE	SCREENING PROCEDURE/TEST NOT VALID FOR DATE OF SERVICE
	EXPLANATION:	The Date of Service on the claim was before the date that the screening procedure/test became reimbursable for CHDP providers.
24.	MESSAGE:	SCREENING PROCEDURE/TEST NOT VALID FOR MALE
	EXPLANATION:	On the claim, the box denoting sex indicated the patient was male. The test indicated is for females only.
25.	MESSAGE:	DUPLICATE TEST
	EXPLANATION:	The same Other Test (Codes 13-22) was entered on more than one line for the same test.
26	MESSAGE:	HEIGHT/LENGTH MEASUREMENT REQUIRED
	EXPLANATION:	Height/length in inches and number of quarter (1/4) inches was missing or incorrectly entered.
27	MESSAGE:	WEIGHT MEASUREMENT REQUIRED
	EXPLANATION	Weight in pounds and to the nearest ounce was missing or incorrectly entered.
28	MESSAGE:	BLOOD PRESSURE MEASUREMENT REQUIRED
	EXPLANATION:	Systolic/Diastolic blood pressure values were missing or incorrectly entered for a child three (3) years of age or older.
29	MESSAGE	IMMUNIZATIONS--SHOT CODE AND/OR ASSESSMENT MISSING OR INCORRECT ON BLANK LINE(S) 1-7
	EXPLANATION:	The shot code and/or assessment for the indicated shot were missing or incorrectly marked on the claim. A checkmark was required in Column A, B, C, or D.
30	MESSAGE:	NO PATIENT VISIT CODE
	EXPLANATION	The patient visit (new/extended or routine) was missing or incorrectly marked on the claim.

31 MESSAGE: NO FEES ON CLAIM
EXPLANATION: No fees were entered on the claim and nothing could be paid.

32. MESSAGE: LINE ITEM FEES NOT ENTERED
EXPLANATION: The total billed amount was entered; however, the fees for the individual services were not itemized.

MESSAGE: PROVIDER NOT ELIGIBLE FOR PAYMENT ON DATE OF SERVICE
EXPLANATION: The provider was not enrolled as an active CHDP provider on the date of service. Any claims processed before the provider's date of activation or after the provider's date of deactivation are denied.

34. MESSAGE: TOBACCO QUESTIONS NOT ANSWERED
EXPLANATION: Answers to Tobacco questions were missing or incomplete. "Yes" or "No" was required for every question.

35. MESSAGE: PRIOR PM 160 DATE SAME AS THE DATE OF SERVICE ON THIS CLAIM
EXPLANATION: The prior PM 160 date filled in on the claim was the same as the date of service on the claim. To process this claim, however, the prior PM 160 date cannot be the same as the date of service.

MESSAGE: PM 160 SUBMITTED AS A PARTIAL SCREEN OR THE PARTIAL SCREEN BOX WAS CHECKED AND NO PRIOR PM 160 DATE WAS SUPPLIED
EXPLANATION: A prior PM 160 date was required for a claim submitted as a partial screen.

37. MESSAGE: PATIENT'S MEDI-CAL AID CODE NOT ELIGIBLE FOR CHDP SERVICES
EXPLANATION: The patient's Medi-Cal Aid Code did not qualify the patient for CHDP services with this Medi-Cal Identification Number. The patient may be eligible for CHDP services by establishing low-income eligibility.

38. MESSAGE: VALID MEDI-CAL IDENTIFICATION NUMBER REQUIRED
EXPLANATION: The Medi-Cal identification number provided in the patient eligibility section on the claim was not valid.

39. MESSAGE: PATIENT WITH MEDI-CAL AGE 21 OR OVER
EXPLANATION: The patient had Medi-Cal and was age 21 years or older on the date of service. The patient was no longer eligible for CHDP exams at age 21.

MESSAGE: PATIENT LESS THAN 2 DAYS OLD
EXPLANATION: The patient's date of birth is less than two days from the date of service. The age of the patient was younger than routinely allowed for CHDP reimbursement, and no reason for the visit was given.

41 MESSAGE: PATIENT ENROLLED IN PREPAID HEALTH PLAN (PHP), HEALTH MAINTENANCE ORGANIZATION (HMO), HEALTH CARE PLAN (HCP) OR HEALTHY FAMILIES PLAN (HF)

EXPLANATION: The patient was enrolled in a Prepaid Health Plan (PHP), Health Maintenance Organization (HMO), Health Care Plan (HCP) or Healthy Families Plan (HF) on the date of service. Patients must have received services from their PHP, HMO, HCP, or HF plan unless preventive services were not a covered benefit. A denial is required from the other health insurance prior to submitting a claim to CHDP.

42. MESSAGE: CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) STATED PATIENT WAS 19 YEARS OF AGE OR OLDER

EXPLANATION: The answer to the question on DHS 4073 "Is the patient less than 19 years of age?" indicated the patient was 19 years of age or older.

43. MESSAGE: CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) REPORTED PATIENT HAD MEDI-CAL ON DATE OF SERVICE

EXPLANATION: The question on DHS 4073 – "Is the patient on Medi-Cal Now?" was answered "Yes." If the patient has full scope, no share of cost Medi-Cal, the DHS 4073 should not have been used.

44. MESSAGE: CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) STATED PATIENT ENROLLED IN A PREPAID HEALTH PLAN

EXPLANATION: The question on DHS 4073 – "Is the patient in a Prepaid Health Plan?" was answered "Yes." If the patient is in a Prepaid Health Plan that includes coverage for preventive health services, the provider cannot be reimbursed for the services in the CHDP fee-for-service-system.

45. MESSAGE: CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) INDICATED PATIENT INCOME GREATER THAN ALLOWED FOR CHDP ELIGIBILITY

EXPLANATION: The answer to the question on DHS 4073 – "How much money does your family make before taxes?" indicated the family income was greater than is allowed by the CHDP Income Eligibility Determination Table currently in effect.

46. MESSAGE: NUMBER IN THE FAMILY WAS ZERO ON CHDP ELIGIBILITY INFORMATION FORM (DHS 4073)

EXPLANATION: A number greater than zero was required for the answer to the question on DHS 4073 "How many people in your family?"

47. MESSAGE: INCOME MISSING ON CHDP ELIGIBILITY INFORMATION FORM (DHS 4073)

EXPLANATION: The answer to the question on DHS 4073 – "How much money does your family make before taxes?" was left blank.

48. MESSAGE: INCOME INDICATOR ON CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) NOT A MONTH OR YEAR

EXPLANATION: Income on the DHS 4073 Eligibility Form was not designated as a monthly or yearly amount.

49. MESSAGE: ANSWERS TO THE ELIGIBILITY QUESTIONS # 1 - #3 ON THE CHDP ELIGIBILITY INFORMATION FORM (DHS 4073) WERE NOT ANSWERED "YES" OR "NO"

EXPLANATION: One or more questions on Eligibility Form DHS 4073 were not answered, or were answered both "Yes" and "No."

50. MESSAGE: MEDI-CAL IDENTIFICIATION NUMBER NOT VALID FOR THE DATE OF SERVICE

EXPLANATION: The Medi-Cal Identification number entered on the PM 160 was not valid for the date of service being billed.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF CLAIM DENIAL FROM FEE ADJUSTMENT EDIT

08-23-2000

JACKSON, LOUIS R. M.D.
987 LOS ALAMOS DRIVE
YUMA CITY, CA 14568

Provider Number: 00D547891

Dear CHDP Provider:

Your Confidential Screening Billing Report (PM 160) with the following information has been denied payment for the reasons listed below:

PM 160 Information:

Medi-Cal Recipient ID:	478523651
Patient Name:	STEWART, JAMES
Medical Record Number:	345990246
Date of Birth:	07-09-1996
Claim Control Number:	0458796514785
Date of Service:	06-06-2000
Total Fees Billed	$177.56

Reason(s) for Denial (See the CHDP Provider Manual for explanation)

Denial Code	Denial Message
200	TOTAL FEES ON THE CLAIMS WERE ADJUSTED TO ZERO

Fee Adjustment Reasons:

01	DATE OF SERVICE EXCEEDED ONE YEAR BILLING LIMIT
10	PATIENT OUT OF AGE RANGE FOR HEAD START STATE PRESCHOOL

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. If you have any questions regarding this procedure, please contact your local CHDP program.

DENIAL MESSAGES RELATED TO FEE ADJUSTMENT EDITS

1 MESSAGE: DATE OF SERVICE EXCEEDED ONE YEAR BILLING LIMIT
EXPLANATION: PM 160 was received with a date of service after the one (1) year billing limit.

2. MESSAGE: SCREENING PROCEDURE/TEST NOT VALID FOR DATE OF SERVICE (DOS)
EXPLANATION: a) The DOS on the claim was before the date the screening procedure/test became reimbursable for CHDP providers, or b) The DOS on the claim was after the date the screening procedure/test was discontinued as a reimbursable service to CHDP providers.

3. MESSAGE: LINE ITEM FEES NOT ENTERED
EXPLANATION: The total billed amount was entered; however, the fees for the individual service(s) were not itemized.

4. MESSAGE: SCREENING PROCEDURE/TEST ASSESSMENT AND FEES DID NOT MATCH
EXPLANATION: One or more screening procedures/tests were listed and the outcome column was blank or checked as "Refused, Contraindicated, or Not Needed," yet a fee was listed for the procedure.

5. MESSAGE: SCREENING PROCEDURE/TEST INAPPROPRIATE AT THIS AGE
EXPLANATION: Certain screening procedures/tests are not usually appropriate for children at certain ages. The procedure was denied because the child's age was inappropriate and no comments in the Comments/Problems justified the screening procedure/test.

6. MESSAGE: SCHOOL DISTRICT PROVIDER NOT ELIGIBLE FOR REIMBURSEMENT OF VISION AND AUDIOMETRIC TESTS OF SCHOOL-AGE CHILD
EXPLANATION: School districts have a long-standing statutory requirement to provide vision and audiometric tests to all children. Fees for vision and/or audiometric screening have been denied because the patient was school age.

7. MESSAGE: SHOT ASSESSMENT AND FEES DID NOT MATCH
EXPLANATION: One or more shots were listed and the outcome column was blank or checked as "Refused or Contraindicated" or "Already Up to Date" yet a fee was listed.

8. MESSAGE: HISTORY AND PHYSICAL EXAM DISALLOWED ON PARTIAL SCREEN
EXPLANATION: The fee for a "History and Physical Exam" may only be billed on a complete screen. The provider indicated the services with this patient were a Partial Screen or a Screening Procedure Recheck. The history and physical exam was not paid.

9. MESSAGE: PATIENT WITHOUT MEDI-CAL AGE 19 OR OVER
EXPLANATION: The patient had no Medi-Cal and was age 19 years or older on the date of service. The patient was no longer eligible for CHDP exams at age 19.

10. MESSAGE: PATIENT OUT OF AGE RANGE FOR HEAD START STATE PRESCHOOL
EXPLANATION: The patient was too old or too young to qualify for screening procedures/tests for Head Start or State Preschool.

11 MESSAGE: VISION AND/OR AUDIOMETRIC SCREENING PROVIDER NOT ELIGIBLE FOR PAYMENT OF OTHER SCREENING PROCEDURES/TESTS
EXPLANATION: Fees for other screening procedures/tests than vision and/or audiometric were denied because the enrolled provider status in CHDP allows the provider to claim only vision and/or audiometric screening procedures.

12. MESSAGE: CLAIM BILLED AS INFORMATION ONLY
EXPLANATION: A Head Start/State Preschool claim was received with the eligibility box marked as information only, however, fees were present. Fees have been adjusted to zero.

13. MESSAGE: LABORATORY PROVIDER NOT ELIGIBLE FOR PAYMENT OF OTHER SCREENING PROCEDURES/TESTS
EXPLANATION: Fees for screening procedures/tests other than laboratory were denied because the enrolled provider status in CHDP allows the provider to claim laboratory procedures/tests only.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF CLAIM DENIAL FROM CRITICAL EDIT

08-23-2000

SMITH, WILLIAM F. MD
FLUGELMANN BUILDING
1020 FRONT BLVD
SAN JUAN CAPISTRANO, CA 93610

Provider Number: FRG983291

Dear CHDP Provider:

Your Confidential Screening Billing Report (PM 160) with the following information has been denied payment for the reasons listed below:

PM 160 Information:

Medi-Cal Recipient ID:	289632415
Patient Name:	CHIN, HAROLD
Medical Record Number:	424345464
Date of Birth:	01-01-2000
Claim Control Number:	0123458967812
Date of Service:	05-03-2000

Total Fees Billed $ 87.25

Reason(s) for Denial (See the CHDP Provider Manual for explanation)

Denial Code	Denial Message
51	PROVIDER CORRECTIONS TO CLAIM WERE NOT RECEIVED. DATE PROVIDER CORRECTION REQUEST (PCR) WAS SENT: 05-31-2000

OTHER ERRORS IDENTIFIED ON THE PCR:
URINE DIPSTICK
URINE DIPSTICK FEE

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. If you have any questions regarding this procedure, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF CLAIM DENIAL FROM CRITICAL EDIT

08-23-2000

JONES, ROBERT G. MD
1020 2ND. AVENUE
SAN JOSE, CA 90029

Provider Number: CRG983291

Dear CHDP Provider:

Your Confidential Screening Billing Report (PM 160) with the following information has been denied payment for the reasons listed below:

PM 160 Information:

Medi-Cal Recipient ID:	125748963
Patient Name:	HARRELSON, HAROLD
Medical Record Number:	645345464
Date of Birth:	02-01-2000
Claim Control Number:	0123458967823
Date of Service:	05-07-2000

Total Fees Billed $ 68.37

Reason(s) for Denial (See the CHDP Provider Manual for explanation)

Denial Code	Denial Message
52	CORRECTION INFORMATION RETURNED FOR THE CLAIM WAS INVALID. PROVIDER CORRECTION REQUEST (PCR) WAS SENT: 06-02-2000

OTHER ERRORS IDENTIFIED ON THE PCR:
PATIENT NAME
TB MANTOUX
TB MANTOUX FEE

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. If you have any questions regarding this procedure, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF CLAIM DENIAL FROM HISTORY EDIT

08-23-2000

SHORELINE HEALTH CLINIC
555 REDWOOD RD
TIMBERLAND, CA 55555-4444

Provider Number: DEN123456

Dear CHDP Provider:

Payment of the Confidential Screening Billing Report (PM 160) identified below has been partially denied because one or more of the health assessments billed were provided more frequently than allowed by the CHDP periodicity schedule. The comments section of the claim form did not provide adequate reason for additional assessment services outside of the periodicity schedule. All allowable tests and/or immunizations billed on this claim have been processed for payment.

PM 160 Information:

Medi-Cal Recipient ID:	777777777
Patient Name:	GONZALEZ, MARIA
Medical Record Number:	22222222222
Date of Birth:	12-31-1998
Current Claim Control Number:	1234567890123
Date of Service:	08-01-2000
Prior Claim Control Number:	0200345678123
Prior Date of Service:	07-25-2000

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. The appeal must be directed in writing to:

Branch Chief
CHDP Program
714 P Street, Room 350
Sacramento, CA 95814

If you have any further questions about this procedure, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF TRACER/DUPLICATE CLAIM DENIAL FROM HISTORY EDIT

09-01-2000

SMYTHE, ADRIAN Q M.D.
3210 HOLLYWOOD BLVD
LOS ANGELES, CA 93610

Provider Number: PRG666670

Dear CHDP Provider:

The tracer or duplicate Confidential Screening Billing Report (PM 160) identified below has been processed and denied because the original claim was paid (under the prior claim control number (CCN) as referenced):

PM 160 Information:

Medi-Cal Recipient ID:	123456789
Patient Name:	RUSSO, RYAN
Medical Record Number:	4445115200
Date of Birth:	04-29-1998
Current Claim Control Number:	0399060132152
Date of Service:	08-01-2000
Prior Claim Control Number:	0300156398523
Prior Date of Service:	04-20-2000

Please review your remittance advice(s) for payment of the prior CCN. If you find no record of payment and need to request verification or a replacement check, refer to the CHDP Provider Manual for instructions regarding this process.

If you have any questions regarding this denial, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

NOTICE OF PARTIAL CLAIM DENIAL FROM HISTORY EDIT

08-23-2000

WILSON, BRYAN T. MD
123 BLANKENSHIP PLACE, STE. 3
MEDICAL SPRINGS, CA 77654

Provider Number: PRT001029

Dear CHDP Provider:

Payment of the Confidential Screening Billing Report (PM 160) identified below has been partially denied because one or more of the health assessments billed were provided more frequently than allowed by the CHDP periodicity schedule. The comments section of the claim form did not provide adequate reason for additional assessment services outside of the periodicity schedule. All allowable tests and/or immunizations billed on this claim have been processed for payment.

PM 160 Information:

Medi-Cal Recipient ID:	678951236	
Patient Name:	SMITHERS, SUSAN	
Medical Record Number:	MR12395867	
Date of Birth:	03-20-1985	
Current Claim Control Number:	0319294806871	
Date of Service:	08-05-2000	
Prior Claim Control Number:	0293847617283	0293849573822
Prior Date of Service:	07-28-2000	08-01-2000

If you wish to appeal this decision, please refer to the CHDP Provider Manual for instructions regarding the appeal process. The appeal must be directed in writing to:

Branch Chief
CHDP Program
714 P Street, Room 350
Sacramento, CA 95814

If you have any further questions about this procedure, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

PROVIDER APPROVAL LETTER

08-23-2000

WESTERN HEALTH
6136 ACCEPTANCE BLVD
LAKEBROOK, CA 12356

Provider Number: AG3123658
Active Date: 08-15-2000

Dear CHDP Provider Applicant:

Welcome to the CHDP program! The application for your enrollment as a CHDP provider has been processed. You may now begin submitting claims for payment using the *Name, Address,* and *Provider Number* listed above.

- **No claims with "dates of service" prior to the "active date" identified above will be reimbursed.**
- **A copy of this letter has been sent to the CHDP program for the city/county of LONG BEACH.**

If you have any questions concerning this notice or other CHDP program matters, please contact your local CHDP program.

SAMPLE

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

CHANGE IN PROVIDER INFORMATION LETTER

08-23-2000

SNYDER, ROBERT J.
127 W. OAKLEY STREET
SUITE 100, NEWSTROM PLAZA
FIRST CITY, CA 55698-1001

Provider Number: EGS127896
Active Date: 08-18-2000

Dear CHDP Provider:

Recent changes to your CHDP program provider information have been processed. Your Confidential Screening Billing Report (PM 160) must reflect the current information described below.

If you have any questions concerning this notice or other CHDP Program matters, please contact your local CHDP program.

NEW 1ST PROV NAME: PROVIDER ROBERT
OLD 1ST PROV NAME: OLD PROVIDER BOB

NEW 2ND PROV ADDRESS: SUITE 100, NEWSTROM PLAZA
OLD 2ND PROV ADDRESS: SUITE 200, NEWSTROM PLAZA

NEW CITY/STATE: FIRST CITY, CA 55698
OLD CITY/STATE: EMERALD CITY, CA 88877

LETTER 6

Electronic Data Systems (EDS), Fiscal Intermediary
[For the Child Health and Disability Prevention (CHDP) Program]
P.O. Box 15300
Sacramento, CA 95851-1300
(916) 636-1232/1233

MANUAL EDIT LETTER

September 28, 1999

Dear CHDP Provider:

The attached Confidential Screening Billing Report(s) (PM 160) cannot be processed for the reason(s) indicated below. As you make the corrections or additions, please review your entire claim for completeness and accuracy to prevent further delay in payment. All corrections or additions must be initialed by the person making the change.

For instructions or additional information regarding your claim(s), please contact your local CHDP Program. Return the corrected form to:

EDS/CHDP
Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 Confidential Screening/Billing Report

A.	Provider of Service Information Section	(1) Number omitted ___, incomplete ___, incorrect ___ or illegible ___ (2) Name and/or address omitted___, incomplete___, or illegible___ (3) Signature omitted ___ or not original (stamp not acceptable) ___ (4) Other:_____
B.	Patient Information Section	(1) Omitted ___, incomplete ___, or illegible ___ (2) Other: _____
C.	Patient Eligibility Section	(1) Omitted ___, incomplete ___, or illegible ___ (2) Indicated DHS 4073 must accompany claim ___ (3) Other:_____
D.	Report (PM 160)	(1) Original not submitted (photocopy is not acceptable) (2) Other: _____

DHS 4073 CHDP Eligibility Information form

The DHS 4073 must:	(1) Have original signature (photocopy is not acceptable) (2) Be completed: i.e., each question is answered ___ (3) Be signed by a parent or guardian ___ (4) Be accompanied by PM 160 ___ (5) Other:_____

III. Other (please explain):

_____
_____
_____
_____